NURSE AIDE TRAINING PROGRAM
APPLICATION FOR APPROVAL
North Dakota Department of Health
Division of Health Facilities
(11-2000)

FACILITY/AGENCY
1. Legal name of facility offering the nurse aide training program:
2. Address of facility:
3. Name of administrator of facility:
4. Name, title, and address of individual preparing this form:
5. Telephone number:
6. Name and address of chairman of the board (if applicable):
NURSE AIDE TRAINING PROGRAM
7. Planned date of implementation of program:
8. Frequency and sequence of program offerings:
9. Planned number of students per class:
Program Coordinator: 10. Name and title of registered nurse program coordinator: North Dakota license number:
11. Describe the program coordinator's years of nursing experience and the number of years of experience in the care of the elderly and chronically ill in relation to the following: Name and location of facility, years of employment, full or part time employment, and responsibilities:
12. Attach a copy of the certificate received for the "Train the Trainer" program attended by the program coordinator (if available)

13. Will the program coordinator act as the instructor for the nurse aide training program?
Yes ☐ No ☐

If the answer to number 13 is no, complete the following information for **each** instructor. Make copies as needed for each additional instructor.

Instructors (attach additional pages if necessary):
14. Provide the following information relating to the instructor(s):

a. Name and title of instructor(s) of nurse aide training program
b. North Dakota license number, if applicable
c. Years of employment in profession, including name and location of employer, years of employment (indicate full or part-time) and responsibilities

Supplemental Instructors (attach additional pages if necessary):
15. Identify the name, profession and work experience of each health professional utilized to assist in the instruction of the nurse aide course:

Physical Plant:
16. Describe the classroom space available for instruction. Include location, seating capacity, writing space, lighting, and temperature control:

17. Describe the clinical laboratory space available for instruction, including location, lighting, and temperature control:

18. List the teaching equipment available for simulation of resident care and the audiovisual equipment available for instruction:

Clinical Facility(ies):
19. List the facility(ies) where the students will receive supervised clinical experience:

20. Give the maximum number of students for each facility and the instructor/student ratio for clinical experience:

21. Submit proof of Medicare/Medicaid participation (nursing facilities only)

COURSE CONTENT

22. Submit a copy of the nurse aide training program course curriculum. Include an outline showing:

a. Subjects taught
b. Length of time spent on each subject
c. Length of time spent in supervised practical training
d. When the student will have the first direct contact with residents

23. Length of the course in hours:

24. Number of hours of classroom instruction:

25. Number of hours of supervised practical training:

26. Total number of hours of clinical instruction (if applicable):

27. Describe how students will be evaluated during the course, to determine if they are competent in a given procedure.

28. Describe how you will determine which skills the student has been trained for and determined proficient by the instructor. (Attach the form you are utilizing to document this).

29. Describe the plans for the course evaluation:

30. Provide information regarding how the program is meeting the requirement which prohibits charging of nurse aides who are employed or have an offer of employment by a nursing facility.

COMPETENCY EVALUATION PROGRAM

31. Which state-approved competency evaluation program will your nurse aide training program utilize for testing of nurse aides:

a. ASI ☐
b. ProCare ☐
c. Headmaster ☐

If you use ProCare or Headmaster, please complete page 5

I certify that the information given in this report is true and accurate. Signature of person completing form:	Date:

NURSE AIDE COMPETENCY EVALUATION (proctored at facility)	
1. How do you advise the individual taking the competency evaluation in advance that a record of the successful completion will be included in the state's nurse aide registry?	
2. What provisions are available for oral examinations?	
3. Name of program personnel who will proctor the written (or oral) portion of the competency evaluation: License number (if applicable):	
4. Name of registered nurse who will proctor the skills demonstration part of the competency evaluation: License number (if applicable): Experience in providing care for the elderly or the chronically ill of any age:	
5. Attach a copy of the letter or certificate from nurse aide test vendor confirming the registered nurse identified above is approved as a proctor.	
6. How does the competency evaluation program inform the individual who does not satisfactorily complete the evaluation of the areas which she/he did not pass and that she/he has up to three opportunities to take the evaluation:	
7. Please provide information regarding how the program is meeting the requirements which prohibit charging of nurse aides who are employed by or have an offer of employment by a nursing facility.	
Signature of person completing form:	Date: